

Division of Licensing and Protection
HC 2 South, 280 State Drive
Waterbury, VT 05671-2060
<http://www.dail.vermont.gov>
Survey and Certification Voice/TTY (802) 241-0480
Survey and Certification Fax (802) 241-0343
Survey and Certification Reporting Line: (888) 700-5330
To Report Adult Abuse: (800) 564-1612

June 29, 2016

Ms. Katy Lemery, Manager
Homestead At Pillsbury
3 Harborview Drive
St Albans, VT 05478-4477

Dear Ms. Lemery:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on May 24, 2016. Please post this document in a prominent place in your facility.

We may follow-up to verify that substantial compliance has been achieved and maintained. If we find that your facility has failed to achieve or maintain substantial compliance, remedies may be imposed.

Sincerely,

Pamela M. Cota, RN
Licensing Chief

JUN 20 2016

PRINTED: 06/07/2016
FORM APPROVED

Division of Licensing and Protection

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0605	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 05/24/2016
NAME OF PROVIDER OR SUPPLIER HOMESTEAD AT PILLSBURY		STREET ADDRESS, CITY, STATE, ZIP CODE 3 HARBORVIEW DRIVE ST ALBANS, VT 05478		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R100	Initial Comments: An unannounced onsite re-licensure survey was completed by the Division of Licensing and Protection on 5/24/16. The following are regulatory findings.	R100		
R145 SS=D	V. RESIDENT CARE AND HOME SERVICES 5.9.c (2) Oversee development of a written plan of care for each resident that is based on abilities and needs as identified in the resident assessment. A plan of care must describe the care and services necessary to assist the resident to maintain independence and well-being; This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the home failed to ensure that the plan of care described the care and services necessary to assist the resident to maintain independence and well-being, based on abilities and needs as identified in the resident assessment for 1 of 6 residents sampled (Resident #1). Findings include: Per record review, Resident #1 was assessed by nursing as having the ability to administer their own medications. Per review of the physician's orders, the Medication Administration Record, and interview with staff, the resident was self-administering most of their medications with the exception of eye drops, and an anti-anxiety medication that needs to be counted with the controlled drugs. Per review of the plan of care for Resident #1, there was no plan developed for the self-administration of medications and the	R145	<u>R145</u> We are aware that there was no care plan developed regarding self-administering of medications for this resident. This was corrected immediately with details on the care plan as to what medications the facility administers for the resident and why and which the resident self-administers. RN + DON oversees this process. Administrator to keep accountable. R145 POC accepted 6/23/16 Karen Campos AN	Immediately

Division of Licensing and Protection
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

STATE FORM

6899

LBPY11

If continuation sheet 1 of 2

Division of Licensing and Protection

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0605	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 05/24/2016
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R145	Continued From page 1 associated monitoring and direction to staff regarding this. Per interview on 5/23/16 at 3:45 PM, the Director of Nursing confirmed that there was no care plan developed regarding the self-administration of medications for this resident.	R145		
R266 SS=E	IX. PHYSICAL PLANT 9.1 Environment 9.1.a The home must provide and maintain a safe, functional, sanitary, homelike and comfortable environment. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain at all time a safe environment related to one gas fireplace located in a common area. Findings include: 1. On 5/23/16 at approximately 12:20 PM, the gas fireplace in the common library was found to be on. The external metal framework, heat vent area, and glass measured greater than 200 degrees Fahrenheit by laser thermometer measurement. This fireplace was found to be similar and accessible on two sides, and had no screening devices to prevent accidental contact by residents or others. The Administrator confirmed at the time that the metal framework and glass front was hot and that no screening device was in place. The facility immediately deactivated the gas fireplace.	R266	<u>R266</u> We are aware that the fireplace in the library does not have screen protectors on it. The fire place was immediately turned off at the pilot and screens have been purchased that will be mounted to the fire place for protection against the glass. Administrator to oversee. R266 POC accepted. 6/29/16 Karen Campos RN	Immediately



Homestead

JUN 20 2016

June 17th, 2016

Pamela Cota
Division of Licensing and Protection
HC 2 South, 280 State Drive
Waterbury, VT 05671-2060

To Pamela Cota,

Enclosed you will find our plan of correction resulting from our survey done on May 24th, 2016. We hope that you will find our plan satisfactory. If you have any questions please feel free to contact me. Thank you in advance.

Sincerely,

Katy Lemery
Administrator
Homestead
802-752-2101

PRINTED: 06/07/2016
FORM APPROVED

Division of Licensing and Protection

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NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

HOMESTEAD AT PILLSBURY

3 HARBORVIEW DRIVE
ST ALBANS, VT 05478

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

STATE FORM

0699

LBPY11

If continuation sheet 1 of 2

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NAME OF PROVIDER OR SUPPLIER HOMESTEAD AT PILLSBURY		STREET ADDRESS, CITY, STATE, ZIP CODE 3 HARBORVIEW DRIVE ST ALBANS, VT 05478			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
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Homestead

A Pillsbury Senior Community

3 Harborview Drive
St. Albans, VT 05478
Phone - 802-752-2100
Fax- 802-752-2057
Pillsburymanor.com

To: Pam Cota
Division of Licensing + Protection
Fax: 802-241-0343
Phone: 802-241-0480
Re: Plan of Correction

From: Katy Lemery
Administrator
Pages:
Date: 06-17-16
Fax: 752- 2057

☐ Urgent ☐ For Review ☐ Please Comment ☐ Please Reply ☐ Please Recycle

Comments:

Hard Copy in the mail

**This correspondence is considered confidential. If this message is not intended for you please notify us immediately of our error and destroy this information. It is strictly prohibited by law to copy, distribute, or disseminate any of this information. Not abiding by this could result in a fine, jail time, or both.

Homestead



June 17th, 2016

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Division of Licensing and Protection
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